

# Maine Hospital Financial Performance 1993-2002

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to the Commission to Study Maine's Hospitals  
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Produced for the Governor's Office of Health Policy and Finance

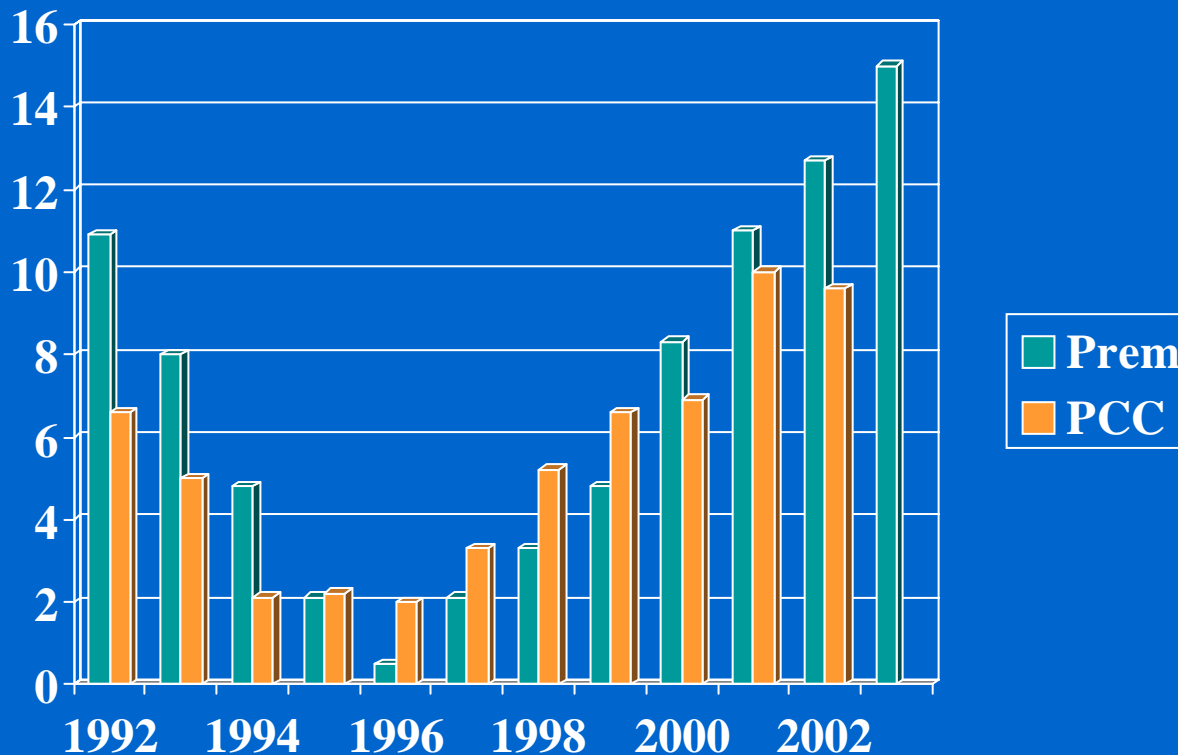
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Health Policy, and The Maine Health Access Foundation

# Context of Hospital Financial Overview

- Rising cost of health premiums
- Role of hospitals in overall health expenditures
- Affordability of premiums for individuals

# Changes in Employer Premiums and Underlying Per Capita Costs

- % Annual Increase

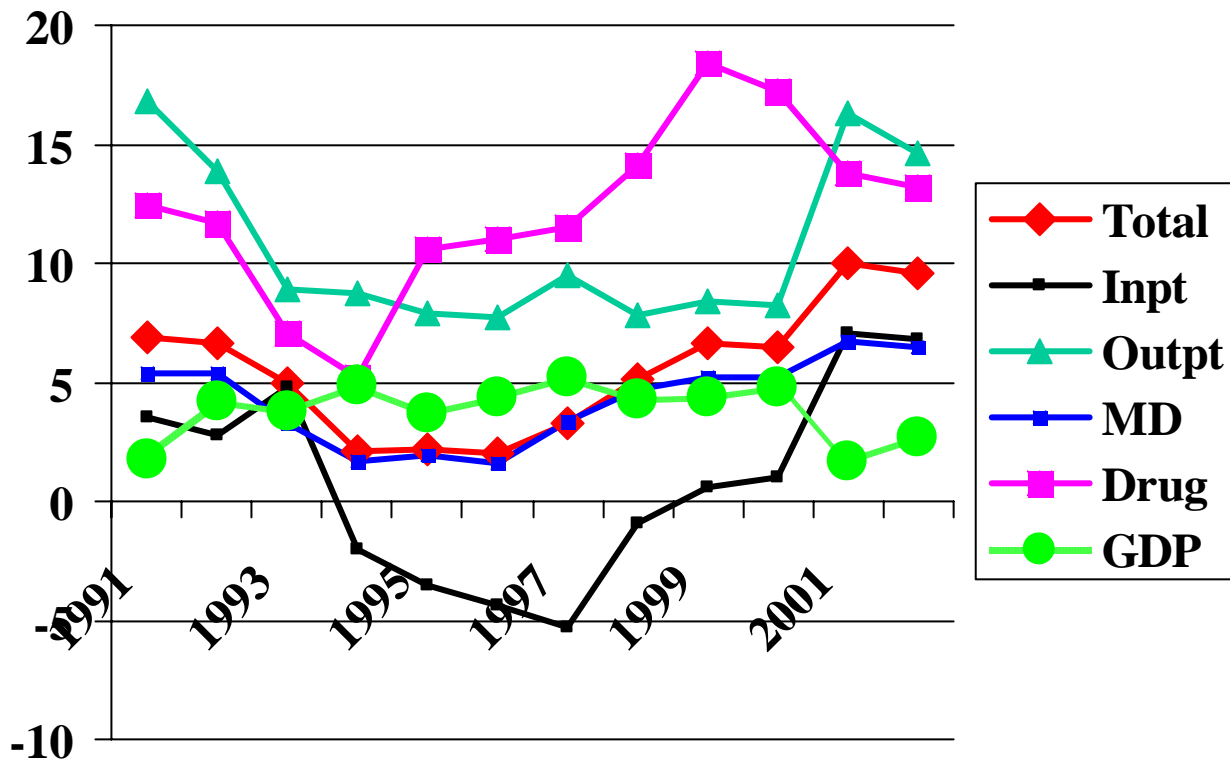


Source: Ctr for Studying Health  
System Change, #23, 11/99 and #22, 11/00  
And #21, 9/01; Watson Wyatt 2002; Heffler et al  
Feb 2003

9/16/2003

# Annual Change in Per Capita Expenditures, 1991 – 2002

- % Annual Change



HSC, :Data Bulletin: “Tracking Health Care Costs: Trends Stabilize But Remain High in 2002”, #25, June 2003

2003 Monthly Premium as % Median State Income,  
Individual Coverage,  
Product most comparable to \$500 deductible, 20%  
coinsurance

State	Monthly Median State Income,2002	25-yr old male	35-yr old couple, 2 children	63 year old couple
MA	\$4200	9%	21%	31%
NJ	\$4400	11%	34%	24%
NY	\$3500	12%	37%	25%
IA – healthy	\$3500	4%	15%	21%
IA – sick	\$3500	16%	47%	75%
KY – healthy	\$3200	3%	15%	22%
KY – sick	\$3200	10%	55%	73%

# Questions Addressed

- What kind of data is needed to understand hospital financial performance?
- What is the difference between “health system” and “hospital” financial performance?
- How do we measure hospital financial performance? What do those measures tell us?
- Where does the cash come from and where does it go?
- How much bad debt and free care do hospitals and health systems provide? What are the major sources of bad debt and free care?

# Data and Methodological Issues

- Data Source: Audited Financial Statements
  - Balance Sheets, Statement of Operation, Statement of Changes in Net Assets, Statement of Cash Flows, Footnotes
- Entity Focus: Individual Hospital
  - Consolidating audited financial statements (balance sheets, statements of operation, statement of changes in net assets)

# Data and Methodology, Cont.

- Hospital entity cash flow statement
  - derived from balance sheet, income statement, and statement of changes in net assets; reconciled to balance sheet change in cash
- Accounting practice standardization
  - Adjusted for differences in hospital reporting practices, eg: unrealized gains and losses, restricted and unrestricted investments, other revenue vs nonoperating revenue



# Generating Statement of Cash Flows Hospital Only, Unrestricted Fund Only

<b>Cash from Operating Activities</b>	Source:
Excess Revenue over Expense	Income Statement
Noncash Adjustments to Excess Rev	Income Statement (depreciation and amortization expense, gains on sales)
Changes in working capital elements	Balance Sheet – current assets excl current cash; current liabilities excl current portion of LTD
<b>Cash Used in Investing Activities:</b>	
Changes in Noncurrent Investments, adjusted for unrealized gains/losses	Balance Sheet and Stmt Chg in NA
Changes in Gross PP&E	Balance Sheet
Changes in Other Noncurrent Assets, adjusted for amortization and other noncash changes	Balance Sheet

## Generating SCF, continued

<b>Cash from Financing Activities:</b>	
Net change in current and noncurrent longterm debt	Balance Sheet
Changes in other noncurrent liabilities	Balance Sheet
Transfers from restricted funds (capital)	Stmt of Changes in NA
Transfers to/from related entities	Stmt of Change in NA
<b>Net Change in Cash (current)</b>	Reconcile sum of the three activities to the change in cash on the B/S

# Translating Financial Information into Financial Judgment

- Compare performance of one set of hospitals to another (ratio analysis)
- Compare performance in current year to prior years (ratio analysis)
- Compare over the long term: source of funds generated (operations, donations, borrowing) to the use of funds (working capital, cash reserves, debt repayment, capital investment) - cash flow statement analysis

# Data and Methodology:

## Entity Issue over Time: Example

- Maine Health
  - Maine Medical Center and Subsidiaries
    - MMC, MMC Medical Services, MMC Realty, Maine Hospitalist Svcs (2002)
    - MMC, MMC Medical Services, MMC Realty, Maine Hospitalist Svcs, Spring Harbor Hospital, Spring Harbor Counseling (2001)
    - MMC, MMC Medical Services, MMC Realty, Spring Harbor Hospital, Spring Harbor Counseling (2000, 1999)
    - MMC, MMC Medical Services, MMC Realty (1998)
    - MMC, MMC Medical Services (1997) – as of 1997, Brighton Medical Center merged into MMC
    - MMC excluding Brighton (1996 and earlier); also the MMC Realty and MMC Medical Services were direct subsidiaries of Maine Medical Center Foundation, not MMC itself

# Maine Health, Continued

- Other Parts of Maine Health, just 2002:
  - Parent (Maine Health)
  - Miles Health Care Inc
    - Miles Health Care, Miles Memorial Hospital, Cove's Edge, Miles Medical Group
  - Western Maine Health Care Corporation
    - Parent, Stephens Memorial Hospital, Market Square Health Care Center, Chapel Valley Boarding Home, Western Maine Multi-Medical Specialists, Stephens Community Healthcare Foundation
  - Spring Harbor Hospital
  - Community Health Services Group
  - Practice Partners
  - Spring Harbor Counseling
  - Maine Physician Hospital Organization
  - Synernet
  - St Andrews Hospital and Subsidiary
    - St. Andrews Hospital, St Andrews Management Company, St Andrews Village

# Maine Health (MH) vs MMC Financial Performance

Ratios	MMC 2002	MMC 2001	MH 2002	MH 2001
Total Margin	6.0%	6.3%	2%	2.3%
Operating Margin	3.2%	3.0%	0.2%	0.4%
Days Cash incl BD	195	194	164	171
Debt Svc Coverage	4.94	5.04	3.47	3.8
Average Plant Age	6.2	6.2	6.6	6.4

# Measuring Financial Health: Ratio Analysis

## Profitability

- Operating margin, total margin
- Markup and deductible

## Liquidity

- Days cash on hand

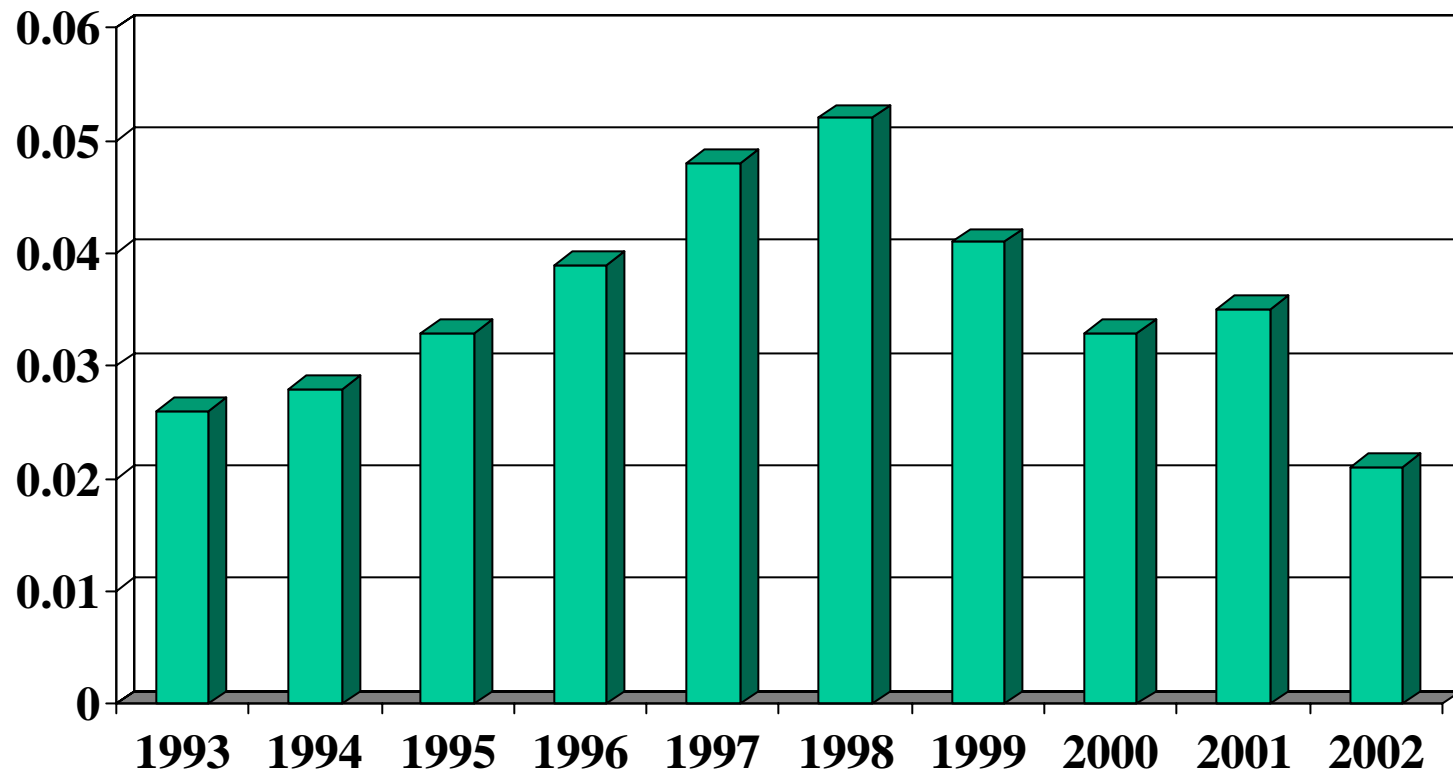
## Solvency

- Equity financing, debt service coverage

## Other

- Average age of plant
- Bad debt and free care as % gross patient revenue

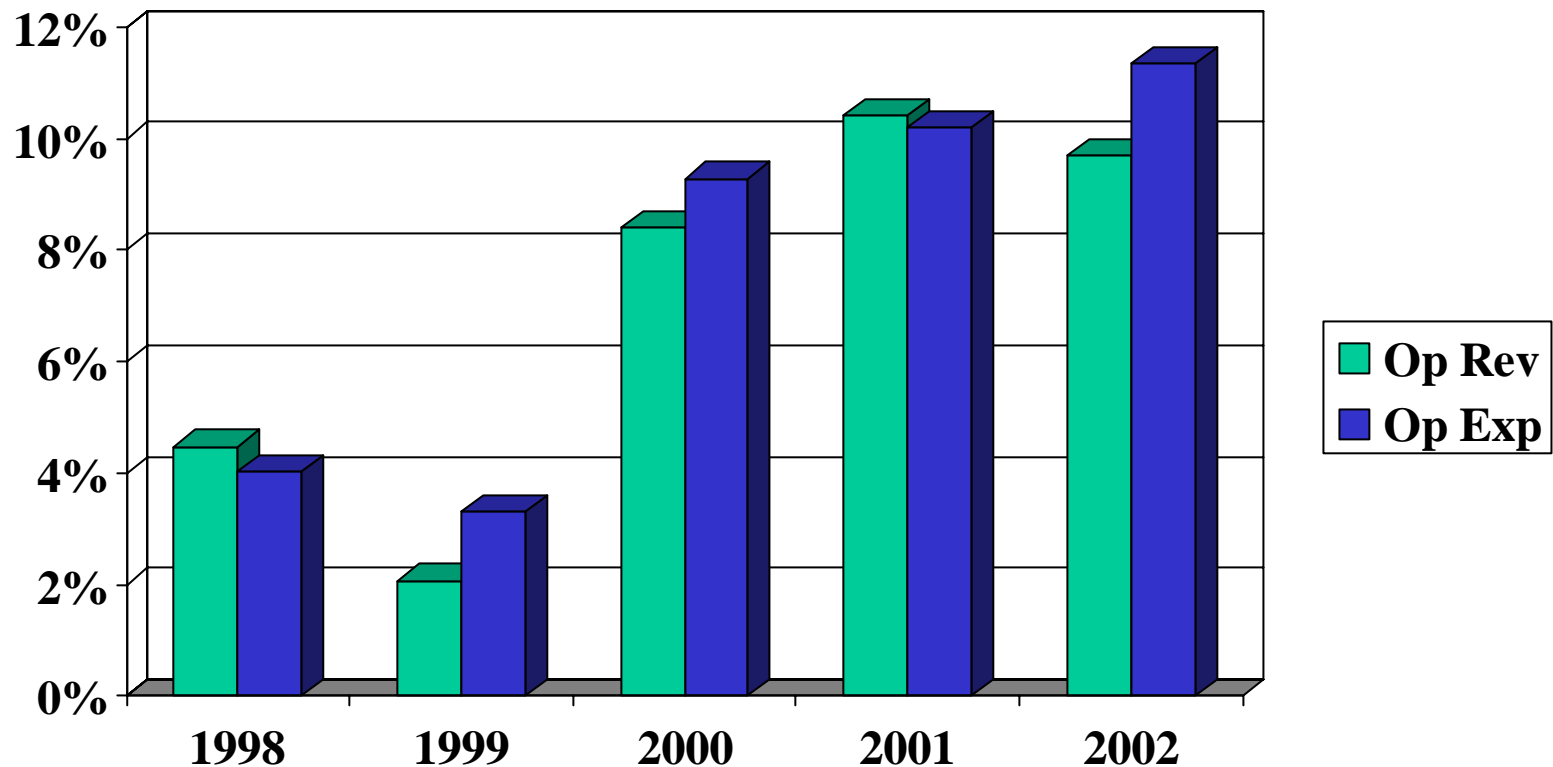
# Aggregate Operating Margins



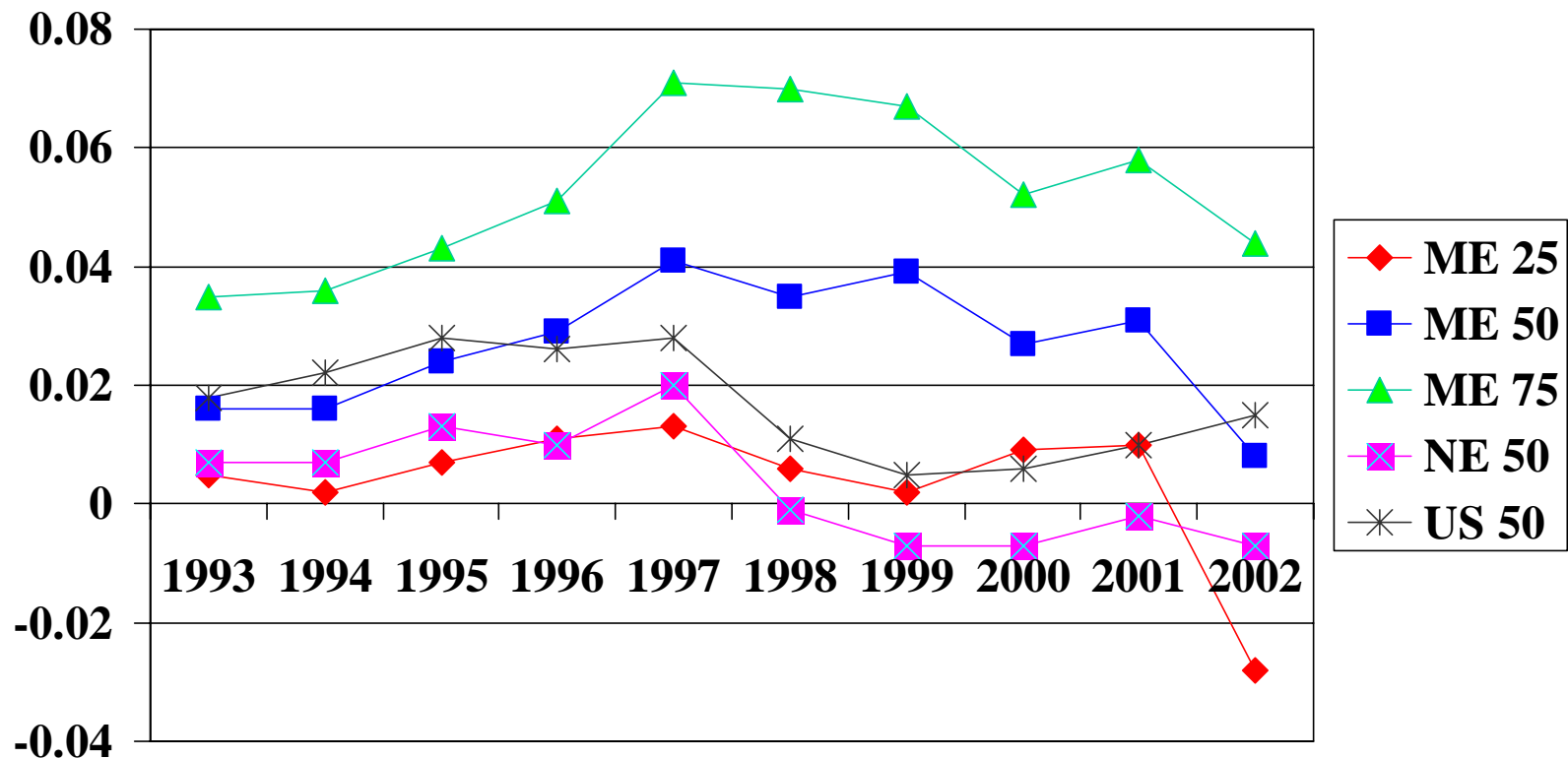


# Aggregate Growth Rates

## Total Operating Revenue and Total Operating Expense

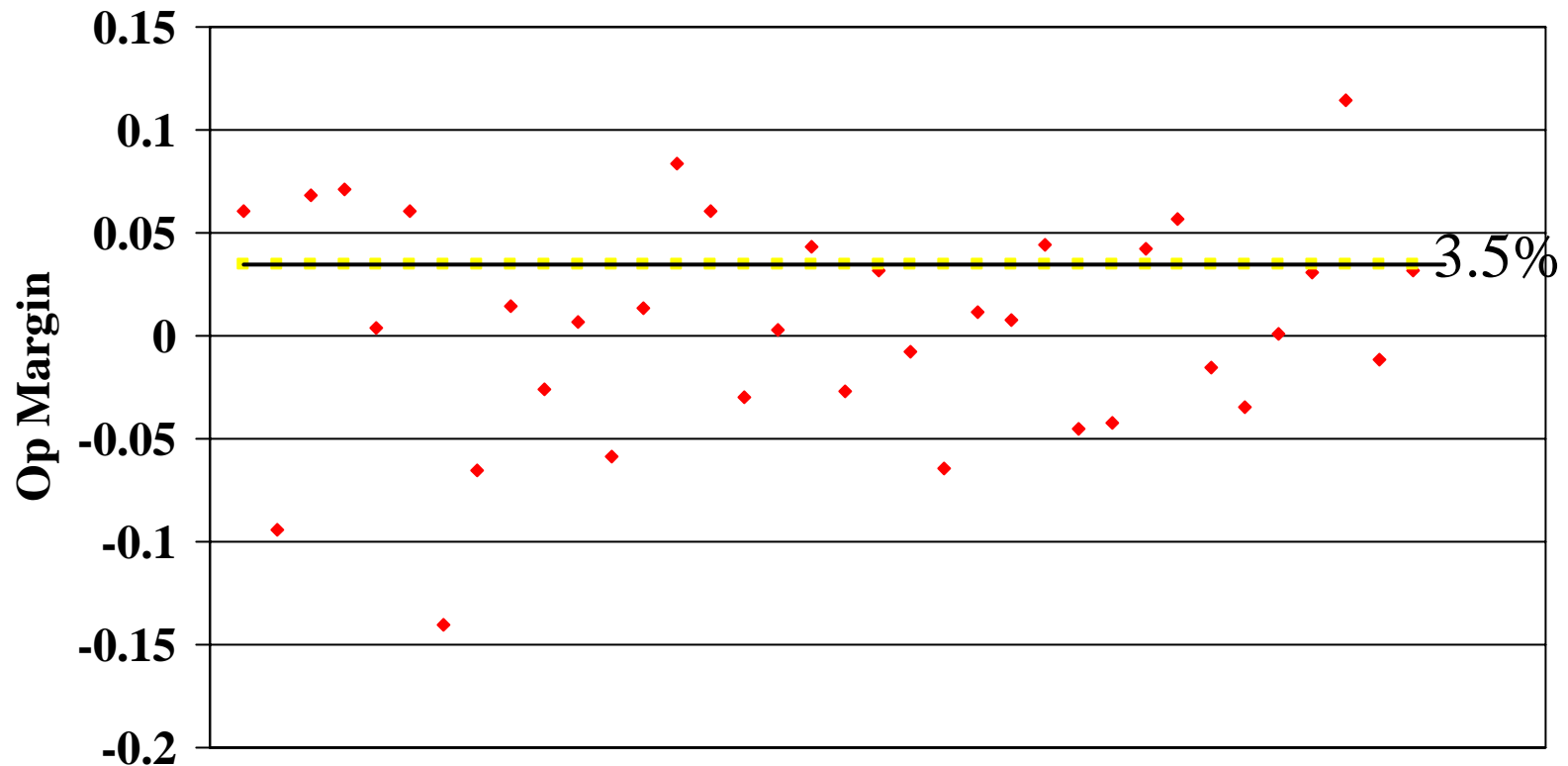


# Operating Margin Distribution 1993-2002



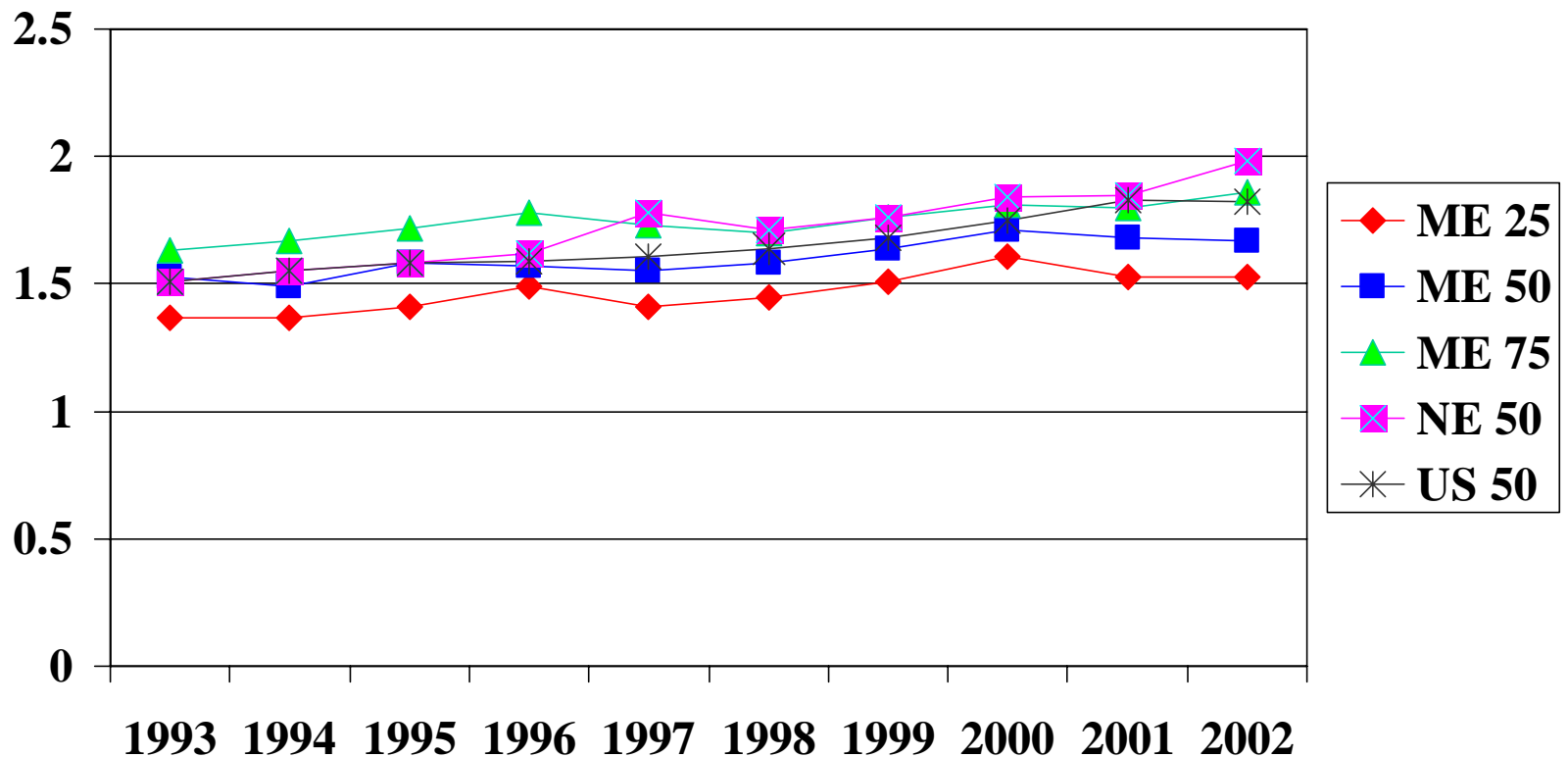
Source of comparison: Almanac 1998-99, 2004, MCR Indicators

# 2002 Distribution of Operating Margins



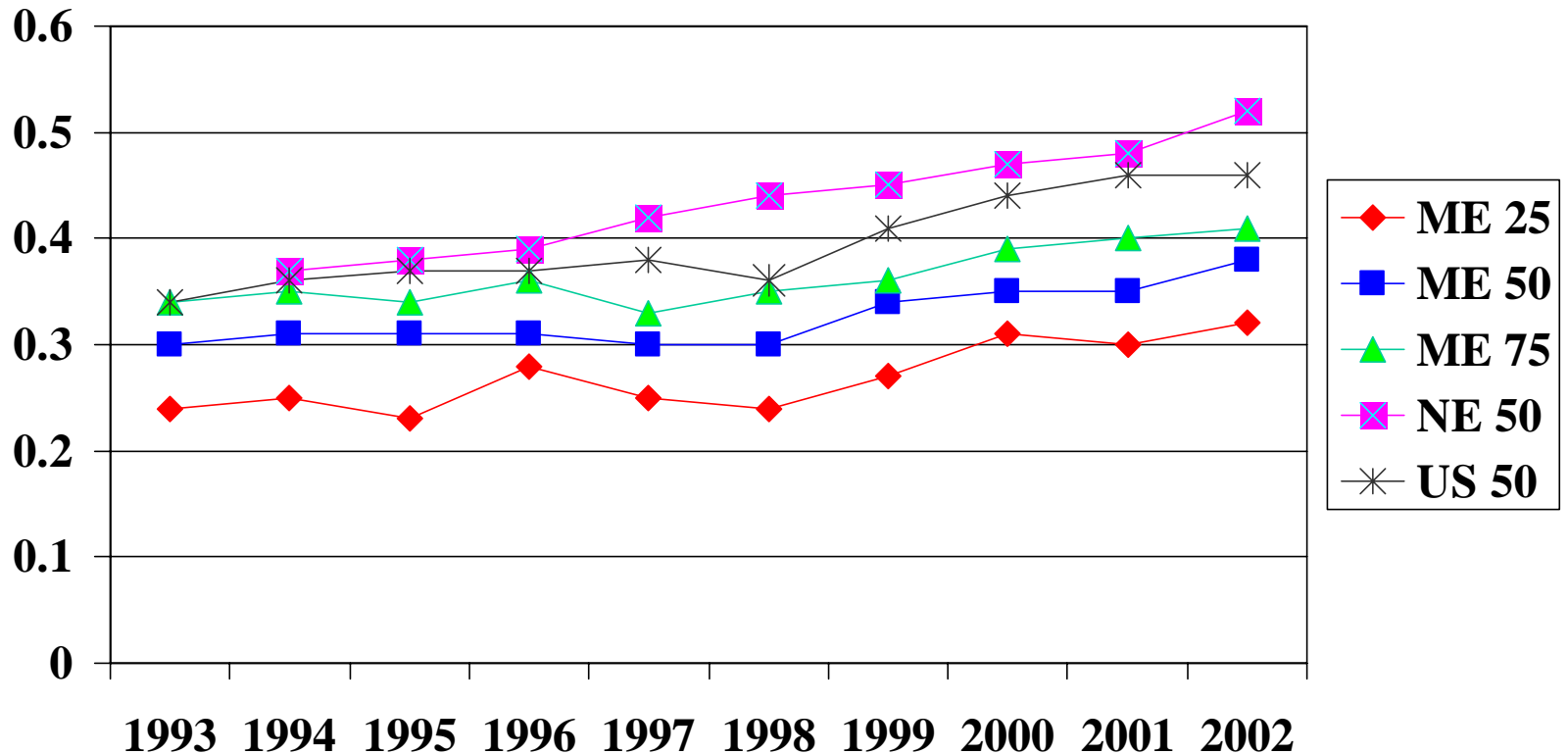
Hospitals with operating margins GT 3.5% generated 87% of aggregate operating income; if they had been limited to a 3.5% operating margin, they would have earned \$17 million less profit

# Markup Trend 1993-2002



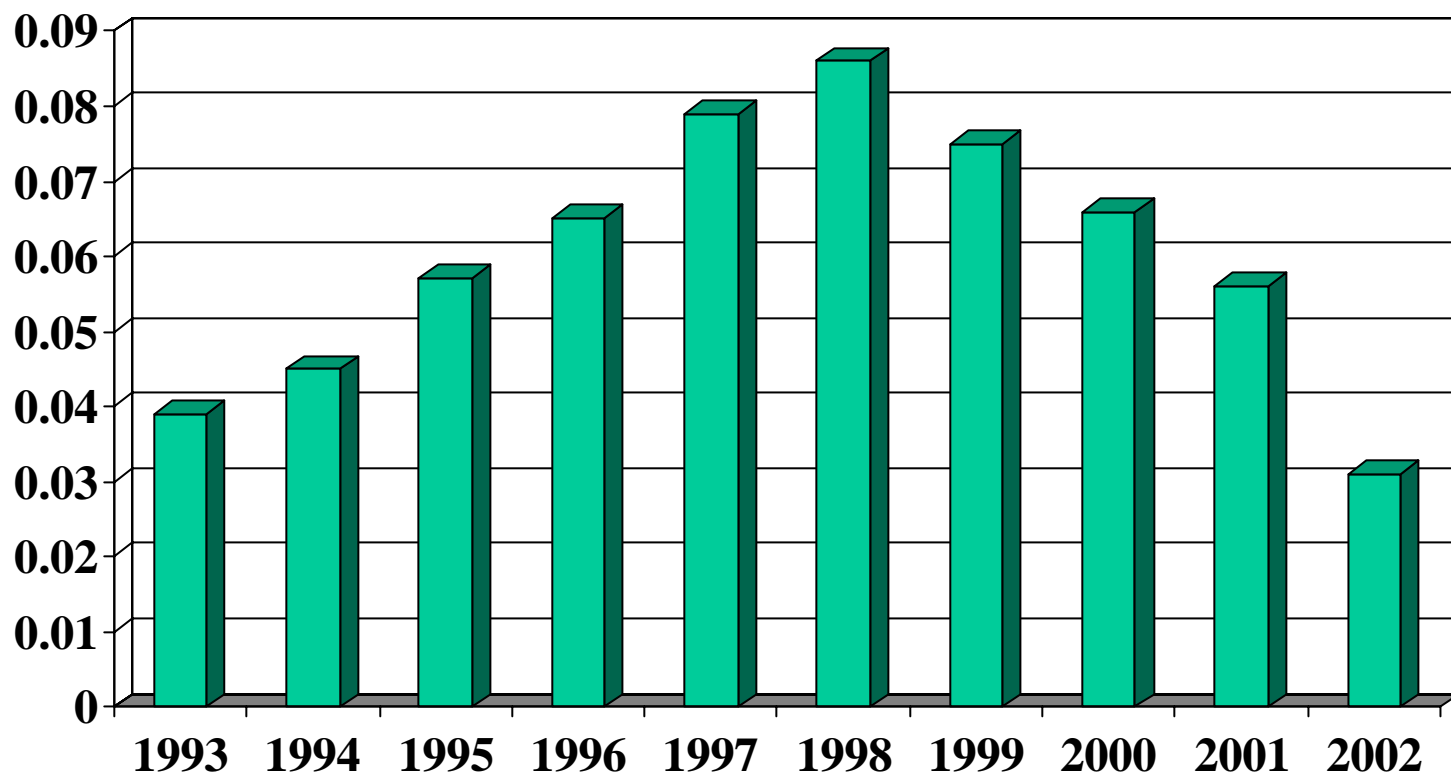
Source of comparison: Almanac 1998-99, 2004, MCR Indicators

# Deductible Trend 1993-2002

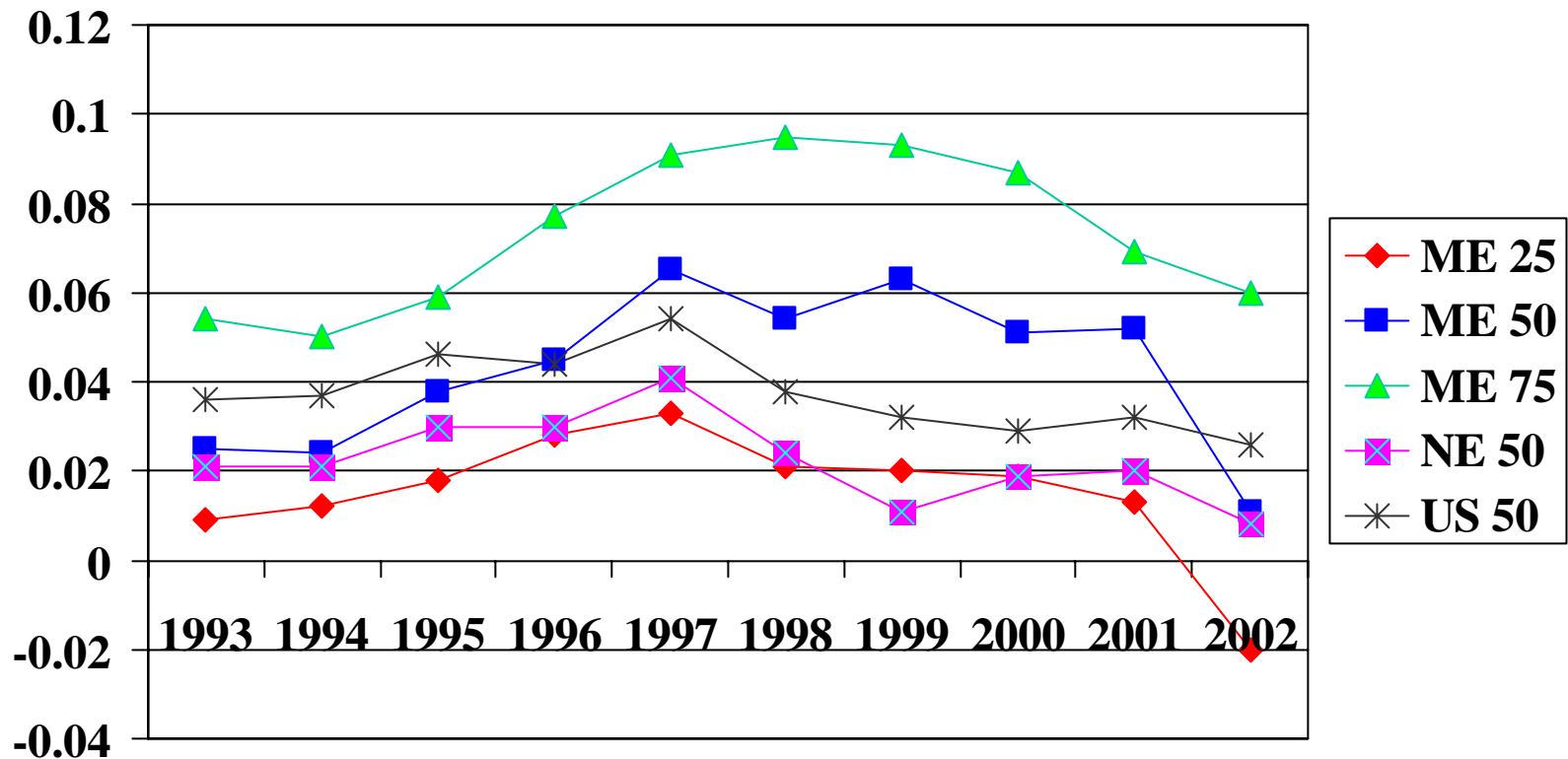


Source of comparison: Almanac 1998-99, 2004, MCR Indicators

# Aggregate Total Margins

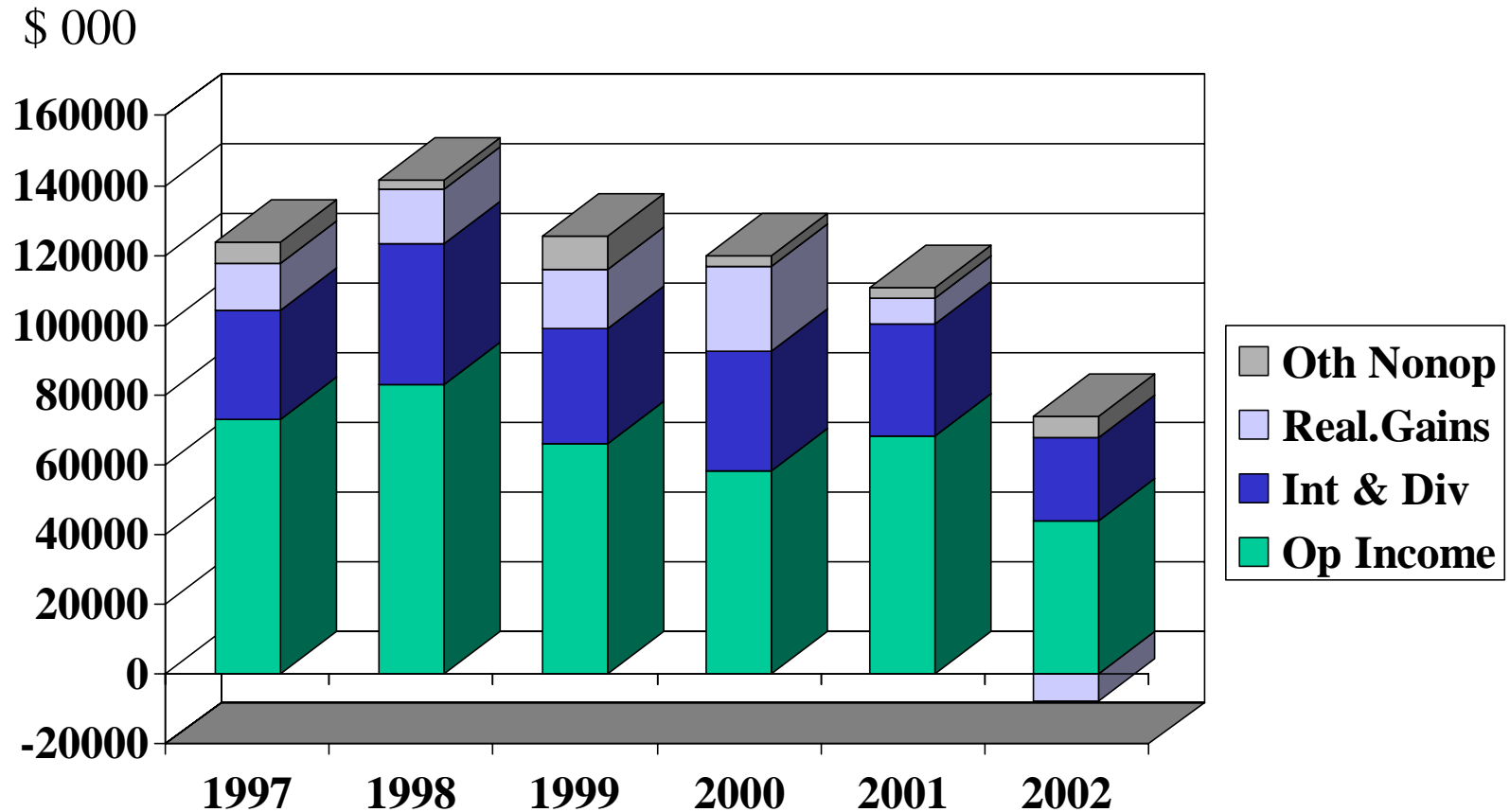


# Total Margin Distribution 1993-2002



Source of comparison: Almanac 1998-99, 2004, Financial Indicators

# Measuring Financial Health: Excess Revenue by Source, 1997-2002

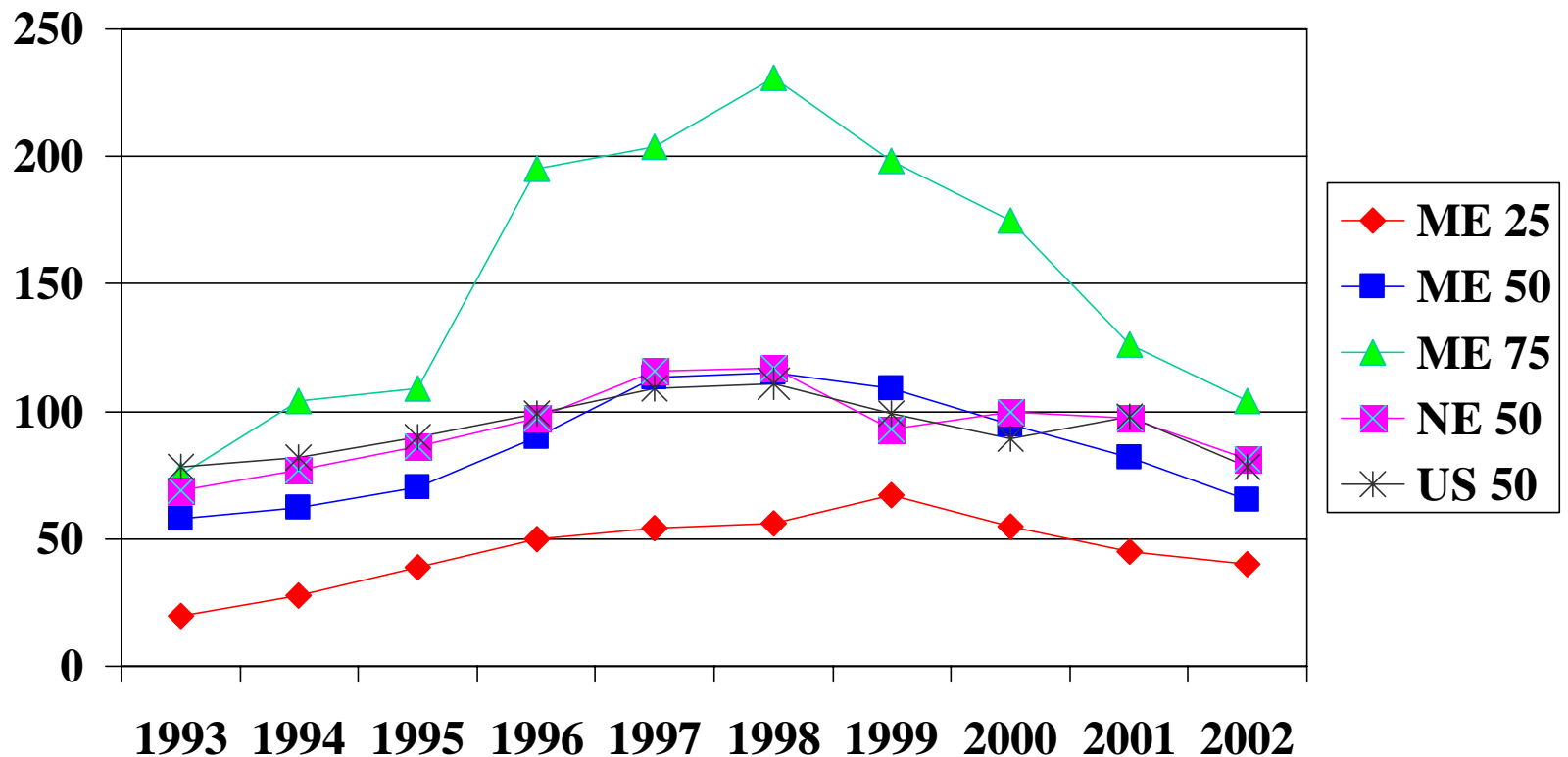


36 acute hospitals in Maine



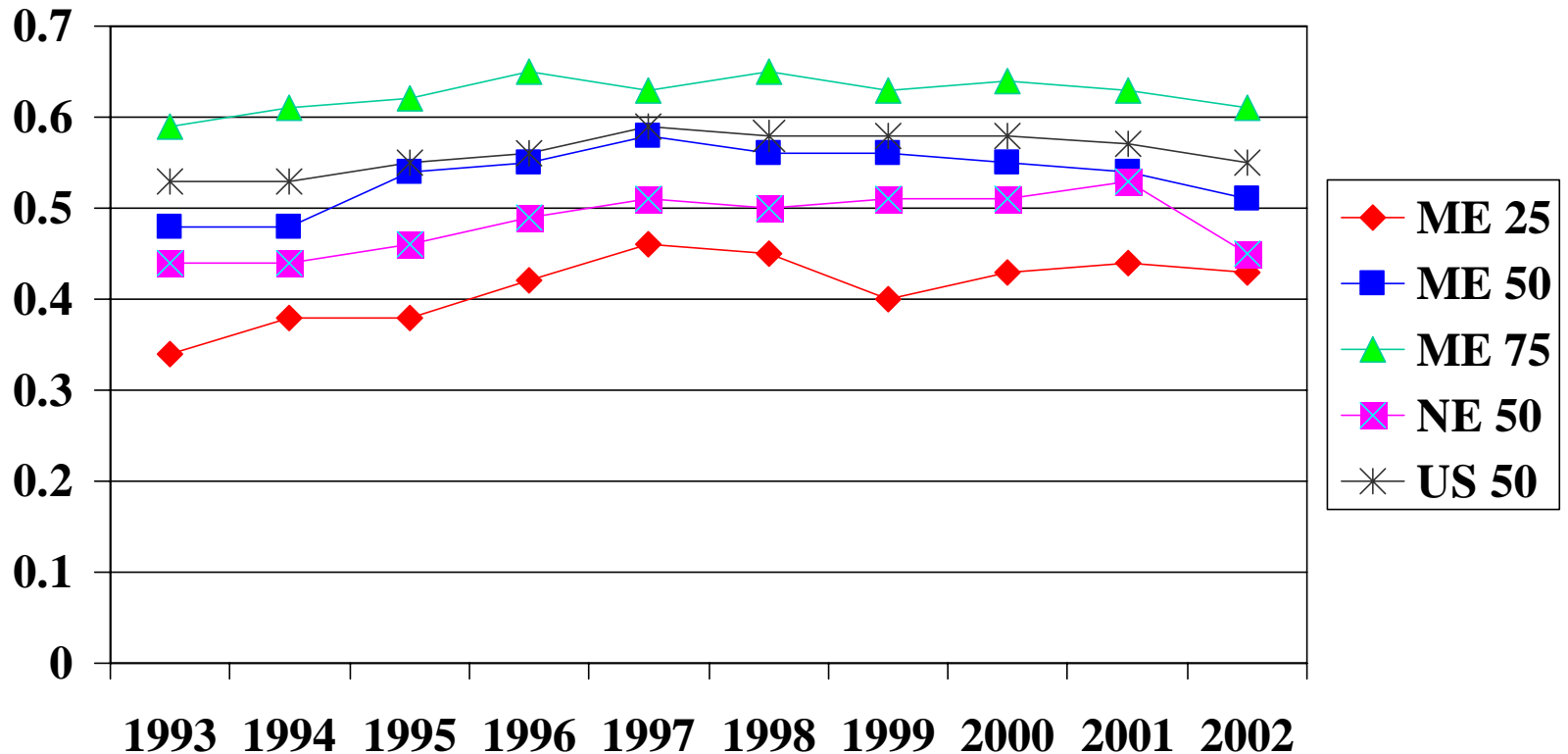
# Days Cash on Hand, Incl BD

## 1993-2002



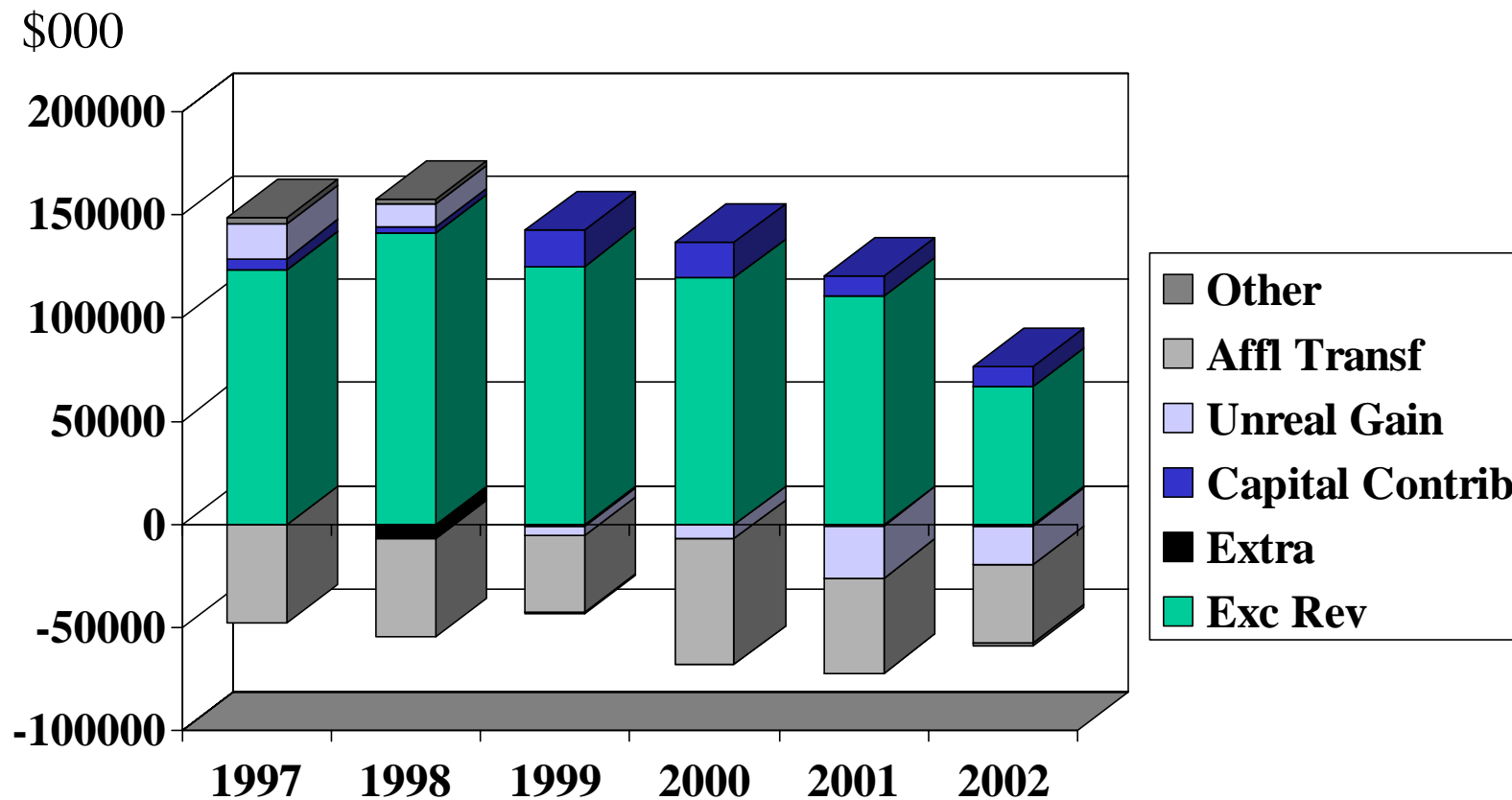
Source of comparison: Almanac 1998-99, 2004, Financial Indicators

# Equity Financing Ratio 1993-2002



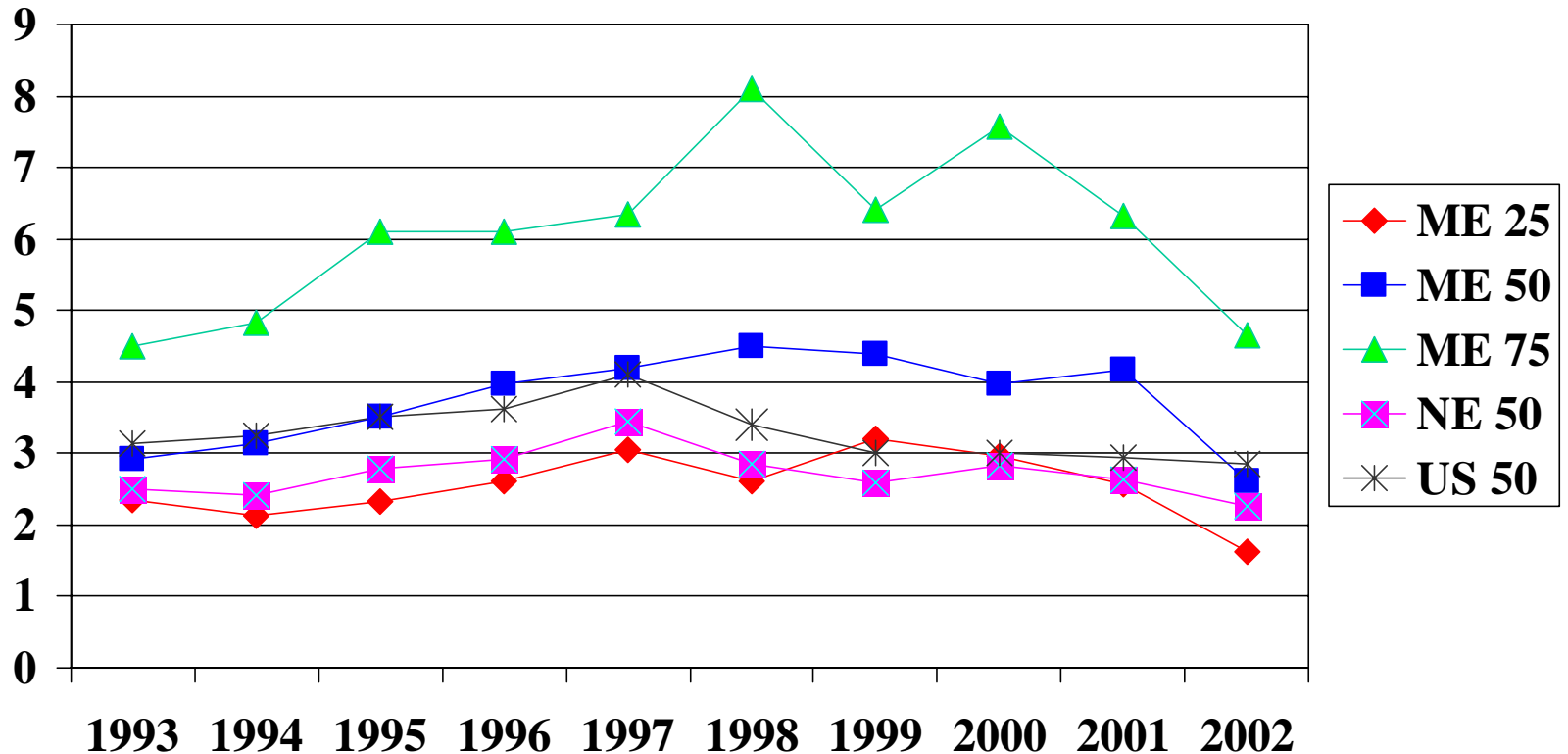
Source of comparison: Almanac 1998-99, 2004, Financial Indicators

# Change in Unrestricted Net Assets 1997-2002



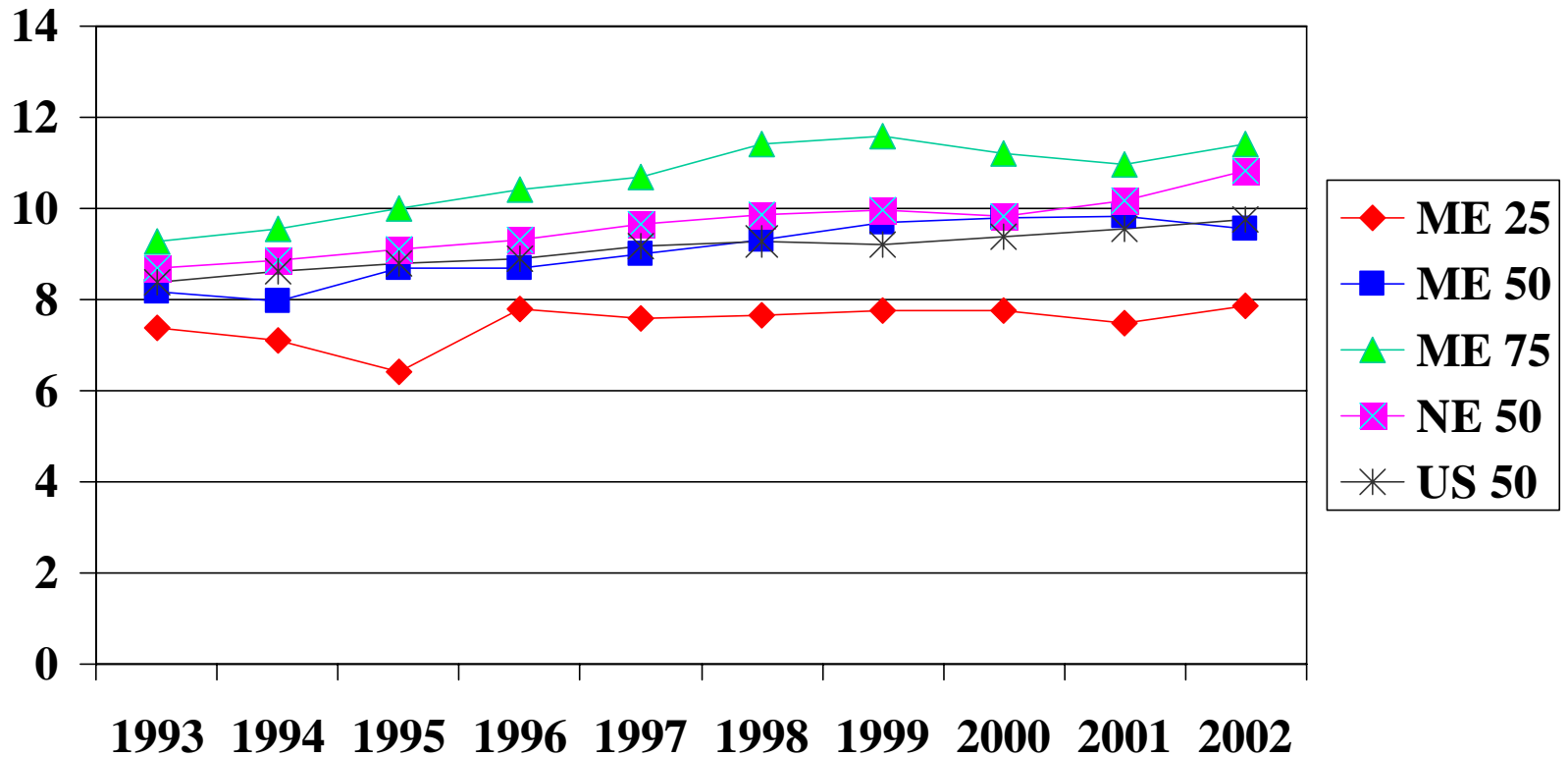
36 Acute Hospitals in Maine

# Debt Service Coverage 1993-2002



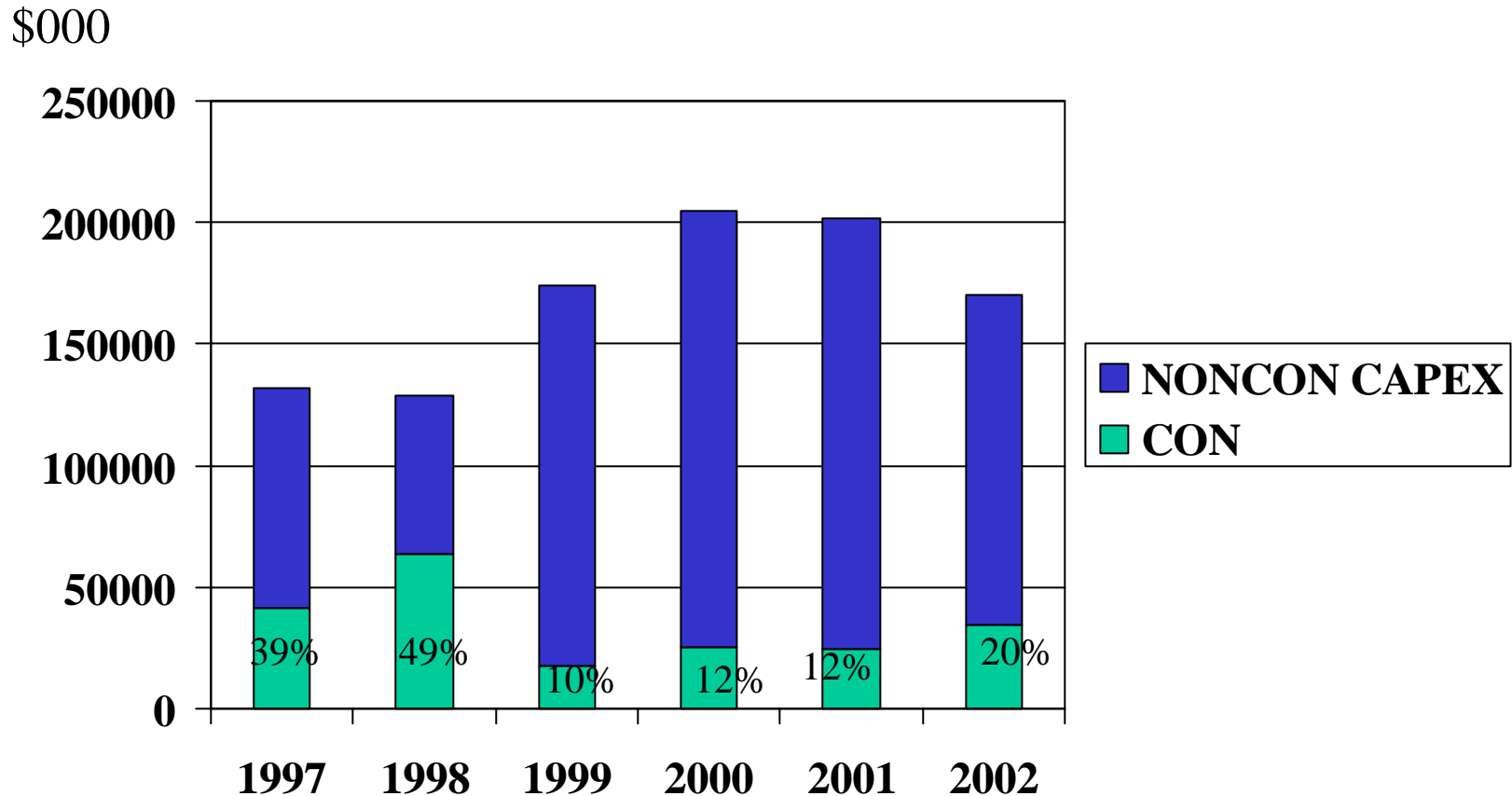
Source of comparison: Almanac 1998-99, 2004, Financial Indicators

# Plant Age 1993-2002



Source of comparison: Almanac 1998-99, 2004, Financial Indicators

# Certificate of Need Capital Approvals Relative to Total Capital Expenditures, 1997-2002



# Maine vs US and New England

## Median Hospital Measures 1996-2002

Measure	Maine vs US		Maine vs NE	
	Yrs ME above	Yrs ME below	Yrs ME above	Yrs ME below
<b>Measures of Profitability</b>				
Operating Margin	6	1	7	0
Total Margin	6	1	7	0
Markup	0	7	0	7
Deductible	0	7	0	7
<b>Measures of Liquidity</b>				
Days Cash on Hand	4	3	1	6
<b>Measures of Solvency</b>				
Equity Financing Ratio	0	7	7	0
Debt Service Coverage	6	1	7	0
<b>Other</b>				
Plant Age	3 ME younger	4 ME older	7 ME younger	0

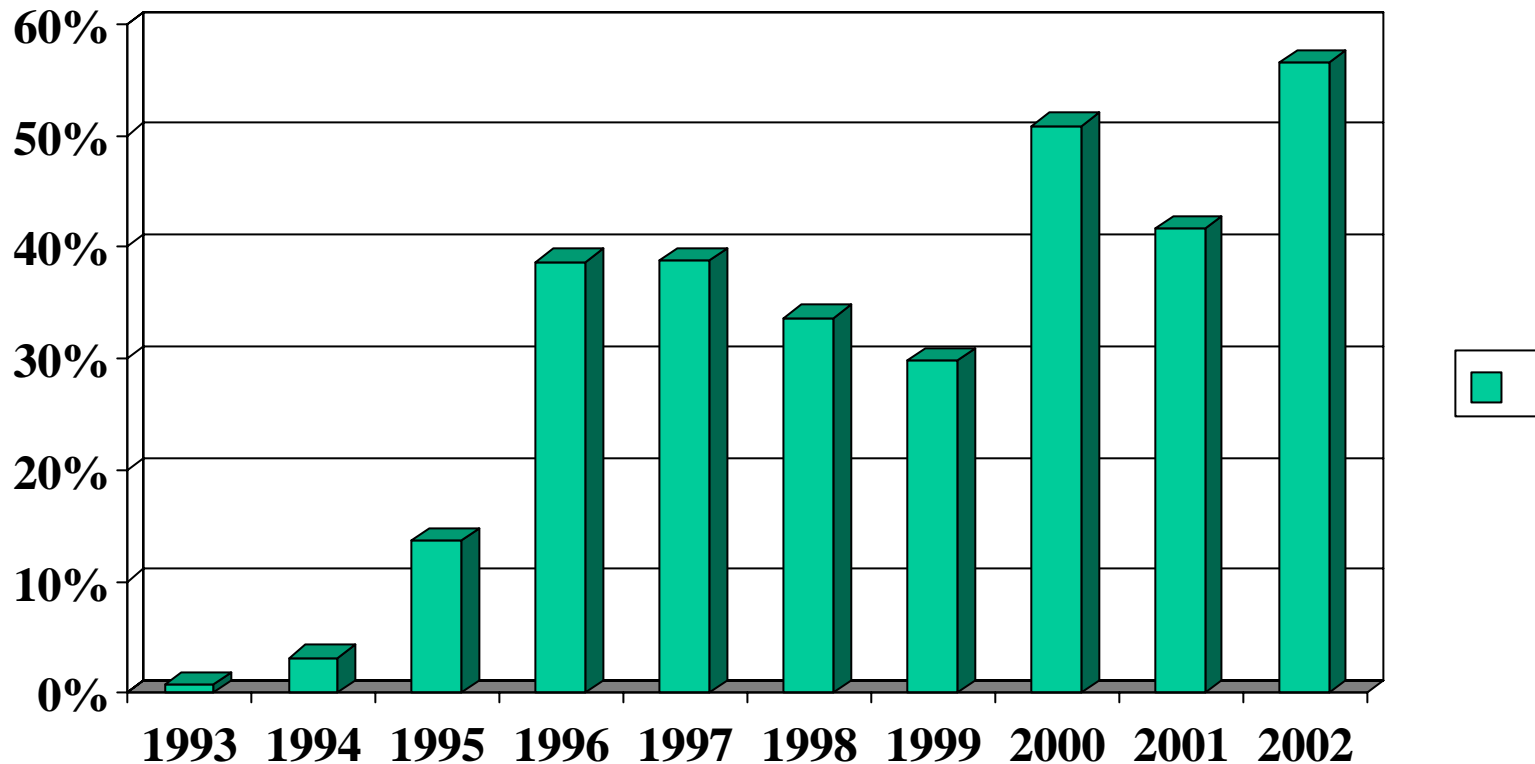
# 10 Year Aggregate Cash Flow

Sources	\$000	% total	Uses	\$000	% total
Operating Income	533,168	28%	PP&E	1,312,119	68%
Nonopng Revenue	391,342	20%	Affiliate transactions	311,298	16%
Noncash expenses	733,638	38%	Cash and securities	192,265	10%
Capital Donations	74,819	4%	Working capital	79,855	4%
Sale of fixed assets	16,782	1%	Other assets	30,760	2%
Net LTD	146,081	8%			
Other liab	21,466	1%			
Total	1,917,297		Total	1,917,297	

Preliminary; missing 12 of 354 hospital-years, all 1993 - 1996



# Percentage of Hospital Excess Revenue Transferred to Subsidiaries and Affiliates within System



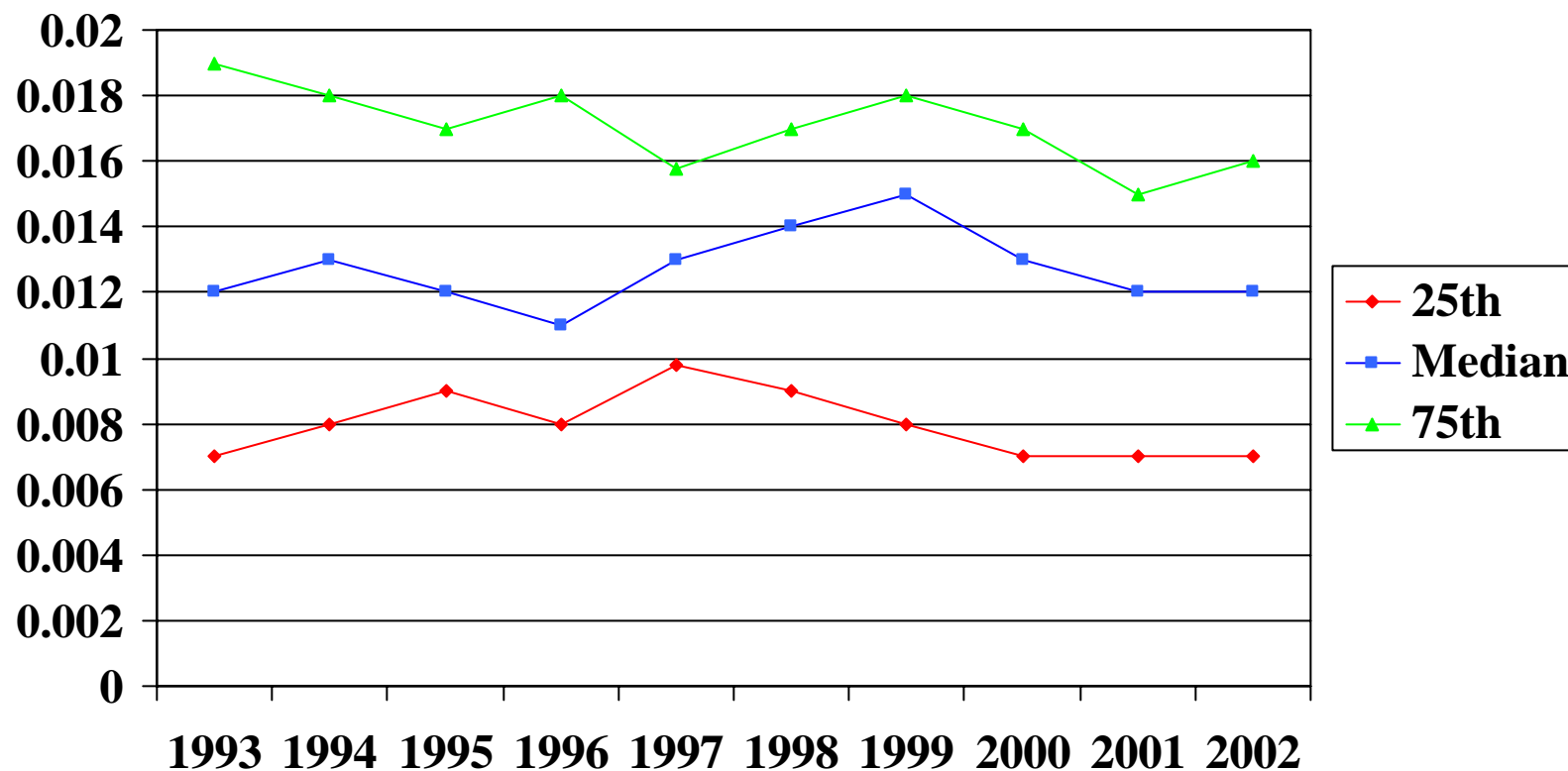
# Nature of Affiliate Transfers From Hospital Entity

Recipient	2002	2001	Combined %
Physician Practices	\$29.7 M	\$24.7 M	58%
Parent or Foundation`	\$2.8 M`	\$10.5 M	14%
Other System Hospital	\$ 5.5 M	\$ 2.5M	8%
Other	\$ 6.5 M	\$12 M	20%
Total	\$ 44.8 M	\$ 49.8 M	

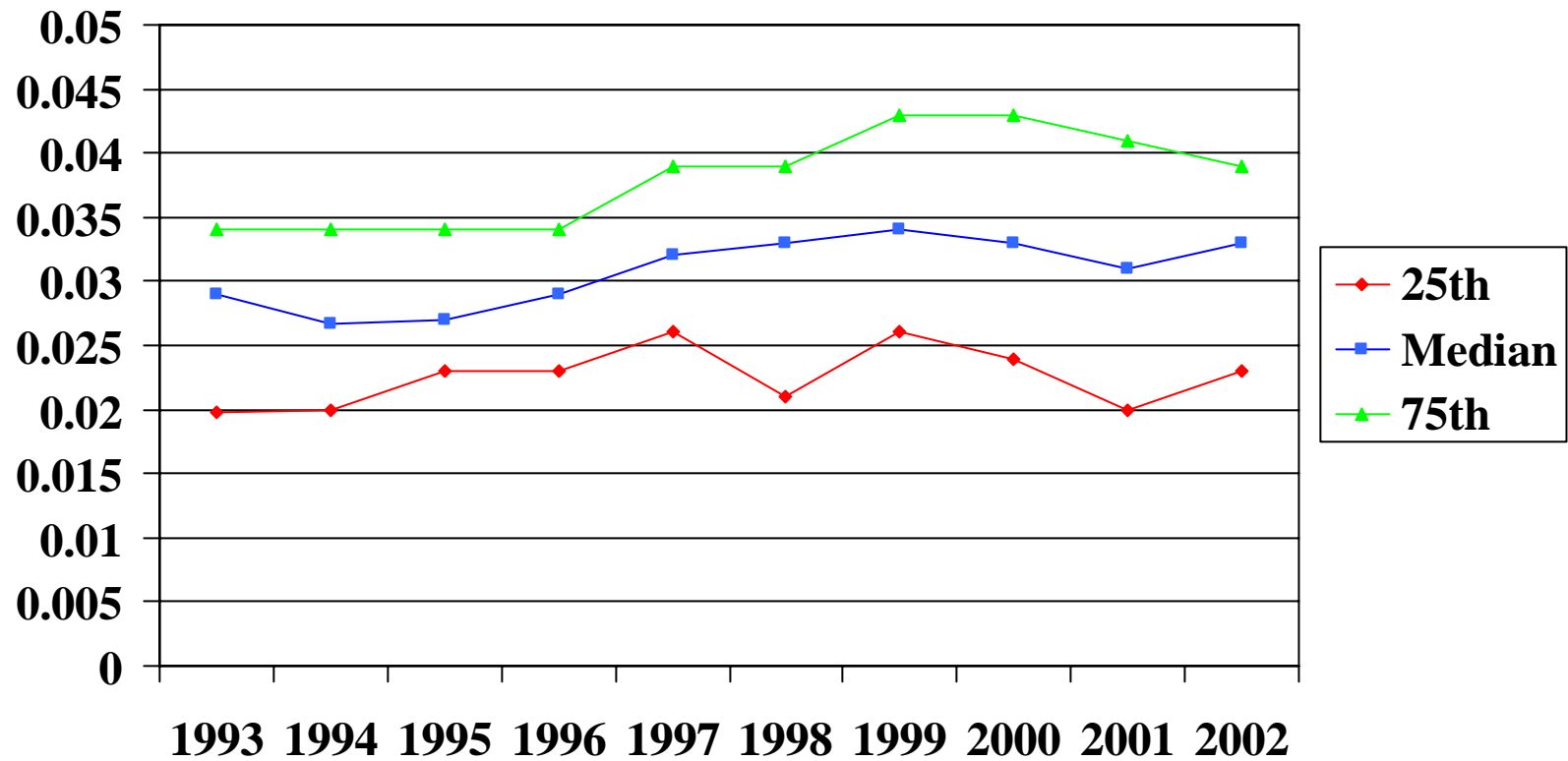
# 5 Year Aggregate Cash Flow

Sources	\$000	% total	Uses	\$000	% total
Operating Income	320,011	25%	PP&E	878,957	68%
Nonopng Revenue	244,000	19%	Affiliate transactions	211,829	16%
Noncash ex	446,557	35%			
Reduce Cash	59,699	5%			
Capital Donations	53,650	4%	Working capital	131,107	10%
Sale of fixed assets	13,404	1%	Other	62,926	4%
Net LTD	138,308	11%			
Other liab	9,190	1%			
Total	1,284,819		Total	1,284,819	

# Free Care % GPSR



# Bad Debt % GPSR



# Source of Bad Debt

- Survey of Hospitals for 2002 and 2003 bad debts
- Only 38% of aggregate bad debt could be broken out for 2002 (only 16 hospitals able to break out privately insured from self-pay)

## Bad Debt by Primary Payer Status

	2002	2003
Medicare	19%	18%
Medicaid	4%	4%
Privately Insured	29%	31%
Uninsured	48%	47%

(source: 16 hospitals of 36 responding to survey)

# Summary

- Maine hospitals have had a profitable decade; most are in very good financial health
- Record cost increases in 2002 were in excess of substantial revenue increases; greater cost discipline in the industry is needed to make health care more affordable in this state of relatively low-income people
- The hundreds of millions of dollars going into system affiliates, particularly for physician practice subsidies as high as 50% of practice expenses, may not be the most efficient, effective way of delivering physician services. Alternative models should be sought, possibly involving more sharing of specialists across hospitals in a regionalization model.